Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
2-4 DAY

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age

Primary Care Provider	Date of Examination	Health Plan Name

Birth Wt.	Weight	Percentile	Height	Percentile	Head Circumference	Percentile

TO BE FILLED IN BY PROVIDER

INITIAL HISTORY

Was history form completed? [ ] Yes [ ] No

Is a 2nd newborn screening (PKU, etc.) necessary? [ ] Yes [ ] No

Was Hepatitis B given in the hospital? [ ] Yes [ ] No

NUTRITIONAL ASSESSMENT [ ] Breast Feeding [ ] Formula (type) _____

Supplements: [ ] Fluoride [ ] Vitamins [ ] Iron

SENSORY ASSESSMENT Vision: Within normal limits? [ ] Yes [ ] No, Refer

Hearing: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
Head		
Eyes (red reflex)		
Ears		
Nose		
Mouth/Throat		
Nodes		
Heart		
Lungs		
Abdomen (cord)		
Rectum		
Fem. Pulse		
Ext. Gen.		
Hip Abduc.		
Extremities		
Spine		
Neuro		
Other		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No

Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Good parenting practices
[ ] Postpartum adjustment
[ ] Infant care/sleep positioning
[ ] Injury prevention
[ ] Closeness with the baby
[ ] Individuality of infants
[ ] Breast / Bottle feeding
[ ] Signs of Illness

REFERRALS

[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
BY 1 MONTH

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age

Primary Care Provider	Date of Examination	Health Plan Name

Birth Wt.	Weight	Percentile	Height	Percentile	Head Circumference	Percentile

TO BE FILLED IN BY PROVIDER

HISTORY INITIAL/INTERVAL
Was history form completed? [ ] Yes [ ] No
Was Hepatitis B given in the hospital? [ ] Yes [ ] No

NUTRITIONAL ASSESSMENT [ ] Breast Feeding [ ] Formula (type) _____
Supplements: [ ] Fluoride [ ] Vitamins [ ] Iron

SENSORY ASSESSMENT Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
Responds to sounds, responds to parent's face and voice, follows with eyes,
(If suspicious, do specific objective testing) Assessment Tool (name) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
Head		
Eyes (red reflex)		
Ears (symmetrical)		
Nose		
Mouth/Throat		
Nodes		
Heart		
Lungs		
Abdomen		
Fem. Pulse		
Ext. Gen.		
Hip Abduc.		
Extremities		
Spine		
Neuro		
Other		

LAB/SCREENING

Hct./Hgb.		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Injury prevention
[ ] Sleep practices
[ ] Sleep positioning
[ ] Bladder and bowel habits
[ ] Nutrition
[ ] Infant Development
[ ] Time to call the doctor
[ ] Infant care
[ ] Plans for next visit

REFERRALS

[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
2 MONTHS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age

Primary Care Provider	Date of Examination	Health Plan Name

Birth Wt.	Weight	Percentile	Height	Percentile	Head Circumference	Percentile

TO BE FILLED IN BY PROVIDER

T _____
P _____
R _____

HISTORY INITIAL/INTERVAL
Comments

NUTRITIONAL ASSESSMENT [ ] Breast Feeding [ ] Formula (type) _____
Supplements: [ ] Fluoride [ ] Vitamins [ ] Iron
SENSORY ASSESSMENT Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer
DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
Vocalizes reciprocally, smiles responsively, attentive to voices, when prone-lifts head, neck, upper chest.
(If suspicious, do specific objective testing) Assessment Tool (name) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
Head		
Eyes (red reflex)		
Ears (symmetrical)		
Nose		
Mouth/Throat		
Nodes		
Heart		
Lungs		
Abdomen		
Fem. Pulse		
Ext. Gen.		
Hip Abduc.		
Extremities		
Spine		
Neuro		
Other		

LAB/SCREENING

Hct./Hgb.		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Injury prevention
[ ] Nutrition
[ ] Sleep positioning/practices
[ ] Fever education
[ ] Family relationships
[ ] Other child care providers
[ ] Talk to baby
[ ] Pacifiers, bottle tooth decay

REFERRALS

[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
4 MONTHS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age

Primary Care Provider	Date of Examination	Health Plan Name

Birth Wt.	Weight	Percentile	Height	Percentile	Head Circumference	Percentile

TO BE FILLED IN BY PROVIDER

HISTORY INITIAL/INTERVAL
Comments

T _____
P _____
R _____

NUTRITIONAL ASSESSMENT [ ] Breast Feeding [ ] Formula (type) _____
Supplements: [ ] Fluoride [ ] Vitamins [ ] Iron [ ] Solids

SENSORY ASSESSMENT Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
Babbles and coos, when prone-holds head erect and raises body on hands, rolls over from prone to supine, grasps rattle, controls head well (If suspicious, do specific objective testing) Assessment Tool (name) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
Head		
Eyes (red reflex)		
Ears (symmetrical)		
Nose		
Mouth/Throat		
Nodes		
Heart		
Lungs		
Abdomen		
Fem. Pulse		
Ext. Gen.		
Hip Abduc.		
Extremities		
Spine		
Neuro		
Other		

LAB/SCREENING

Hct./Hgb.		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Injury prevention
[ ] Choking, aspiration
[ ] Teething
[ ] Solid foods
[ ] Sleep positioning
[ ] Thumb sucking
[ ] Baby-proof home
[ ] Appropriate child care providers

REFERRALS

[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
6 MONTHS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age

Primary Care Provider	Date of Examination	Health Plan Name

Birth Wt.	Weight	Percentile	Height	Percentile	Head Circumference	Percentile

TO BE FILLED IN BY PROVIDER

HISTORY INITIAL/INTERVAL
Comments

T _____
P _____
R _____

NUTRITIONAL ASSESSMENT [ ] Breast Feeding [ ] Formula (type) _____
Supplements: [ ] Fluoride [ ] Vitamins [ ] Iron [ ] Solids

SENSORY ASSESSMENT Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing/Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
Vocalizes single consonants, "dada", rolls over, no head lag when pulled to sit, sits with support, transfers small objects hand to hand. (If suspicious, do specific objective testing) Assessment Tool (name) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
Head		
Eyes		
ENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

	High	Low
Hgb. or Hct.		
Lead Screen: Verbal Risk		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Injury prevention
[ ] Cup, finger foods
[ ] No bottle in bed
[ ] Pool & tub safety
[ ] Teething
[ ] Poisons - ipecac
[ ] Nutrition
[ ] Sleep positioning

REFERRALS

[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
9 MONTHS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	AGE

Primary Care Provider	Date of Examination	Health Plan Name

Birth Wt.	Weight	Percentile	Height	Percentile	Head Circumference	Percentile

TO BE FILLED IN BY PROVIDER

HISTORY INITIAL/INTERVAL
Comments

T _____
P _____
R _____

NUTRITIONAL ASSESSMENT [ ] Breast Feeding [ ] Formula (type) _____ [ ] Whole Milk
Supplements: [ ] Fluoride [ ] Vitamins [ ] Iron [ ] Solids

SENSORY ASSESSMENT Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing/Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
Responds to own name, understands a few words, "no-no" "bye-bye", may say "mama" or "dada" nonspecifically, crawls, sits independently, may pull to stand (If suspicious, do specific objective testing) Assessment Tool (name) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
Head		
Eyes		
ENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

Hgb./Hct.		
	High	Low
Lead Screen: Verbal Risk		
	Yes	No
Lab Lead Screen		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Injury prevention
[ ] Good parenting practices
[ ] Baby-proof home, pool
[ ] Nutrition
[ ] Talk to child
[ ] Self-feeding
[ ] Sleep practices

REFERRALS

[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
12 MONTHS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age

Primary Care Provider	Date of Examination	Health Plan Name

Birth Wt.	Weight	Percentile	Height	Percentile	Head Circumference	Percentile

TO BE FILLED IN BY PROVIDER

HISTORY INITIAL/INTERVAL
Comments

T _____
P _____
R _____

NUTRITIONAL ASSESSMENT [ ] Breast Feeding [ ] Formula (type) _____ [ ] Whole Milk
Supplements: [ ] Fluoride [ ] Vitamins [ ] Iron [ ] Solids

SENSORY ASSESSMENT Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing/Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
Cruises, may take a few steps alone, plays social games, peek-a-boo, precise pincer grasp, drinks from a cup.
(If suspicious, do specific objective testing) Assessment Tool (name) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
Head		
Eyes		
ENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

	High	Low
Lead Screen: Verbal Risk		

	Yes	No
Lab Lead Screen (Required if not done previously)		
Tuberculin Test		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Injury prevention
[ ] Good parenting practices
[ ] Nutrition
[ ] Discipline, praise
[ ] Talk to & name objects
[ ] Dental hygiene
[ ] Sleep practices
[ ] Other

REFERRALS

[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? ☐ Yes ☐ No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
15 MONTHS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age (Months)

Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	Head Circ. (cm)	Health Plan Name

TO BE FILLED IN BY PROVIDER

HISTORY INITIAL/INTERVAL
Comments

T _____
P _____
R _____

NUTRITIONAL ASSESSMENT [ ] Breast Feeding [ ] Whole Milk [ ] Cup [ ] Bottle [ ] Table Foods
Supplements: [ ] Fluoride [ ] Vitamins [ ] Iron

SENSORY ASSESSMENT Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing/Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
Three to six words, points to one or more body parts, understands simple commands, walks well, climbs stairs, feeds self with fingers, listens to a story. (If suspicious, do specific objective testing) Assessment Tool (name)_____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

Tuberculin Test		
	High	Low
Lead Screen: Verbal Risk		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Injury prevention
[ ] Good parenting practices
[ ] Tantrums
[ ] Eating
[ ] Discipline/limits
[ ] Sleep practices
[ ] Nutrition
[ ] Other

REFERRALS

[ ] Dental (Baby bottle tooth decay)
[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
18 MONTHS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age (Months)

Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	Head Circ. (cm)	Health Plan Name

TO BE FILLED IN BY PROVIDER

T _____
P _____
R _____

HISTORY INITIAL/INTERVAL
Comments

NUTRITIONAL ASSESSMENT [ ] Breast Feeding [ ] Whole Milk [ ] Cup [ ] Table Foods
Supplements: [ ] Fluoride [ ] Vitamins [ ] Iron

SENSORY ASSESSMENT Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing/Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
15 to 20 words, some two word phrases, runs stiffly, walks backwards, throws a ball, uses spoon and cup.
(If suspicious, do specific objective testing) Assessment Tool (name) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

Tuberculin Test		
	High	Low
Lead Screen: Verbal Risk		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Injury prevention
[ ] Discipline/limits
[ ] Good parenting practices
[ ] Sleep practices
[ ] Sibling interaction
[ ] Mealtimes
[ ] Toilet training
[ ] Read to child

REFERRALS

[ ] Dental
[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
24 MONTHS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age (Months)

Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	Head Circ. (cm)	Health Plan Name

TO BE FILLED IN BY PROVIDER

T _____
P _____
R _____

HISTORY INITIAL/INTERVAL
Comments

NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] Referred

SENSORY ASSESSMENT Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer
Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
At least 20 words, kick a ball, can follow two-step commands, uses two-word phrases, stacks five or six blocks
(If suspicious, do specific objective testing) Assessment Tool (name) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

Tuberculin Test		
	High	Low
Lead Screen: Verbal Risk		
	Yes	No
Lab Lead Screen (required)		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Changes in appetite
[ ] Brushing teeth
[ ] Read to child
[ ] Toilet training
[ ] Injury prevention
[ ] Nutrition
[ ] Sleep practices
[ ] Child care providers

REFERRALS

[ ] Dental
[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
3 YEARS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age (Years)

Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	B.P.	Health Plan Name

TO BE FILLED IN BY PROVIDER

T _____
P _____
R _____

HISTORY INITIAL/INTERVAL
Comments

NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] Referred
SENSORY ASSESSMENT Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer
Speech: Within normal limits? [ ] Yes [ ] No, Refer
DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
Jumps in place, balances on one foot, rides a tricycle, knows own name, age, sex, copies a circle and a cross.
(If suspicious, do specific objective testing) Assessment Tool (name) _____
BEHAVIORAL HEALTH ASSESSMENT Referral indicated? [ ] Yes [ ] No
Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

	High	Low
Tuberculin Test		
Lead Screen: Verbal Risk		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Injury prevention
[ ] Good parenting practices
[ ] Toilet training
[ ] Discipline
[ ] Dental care
[ ] Nutrition
[ ] Sexual curiosity

REFERRALS

[ ] Dental
[ ] Behavioral Health _____
[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
4 YEARS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age (Years)

Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	B.P.	Health Plan Name

TO BE FILLED IN BY PROVIDER

T _____

P _____

R _____

HISTORY INITIAL/INTERVAL
Comments

NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] Referred

SENSORY SCREEN
Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer
Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
Can sing a song, draws a person with three parts, gives first and last name.
(If suspicious, do specific objective testing) Assessment Tool (name) _____

BEHAVIORAL HEALTH ASSESSMENT Referral indicated? [ ] Yes [ ] No
Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

Tuberculin Test		
	High	Low
Lead Screen: Verbal Risk		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Injury prevention
[ ] Good parenting practices
[ ] Toilet training
[ ] Sexual curiosity
[ ] Nutrition
[ ] Discipline
[ ] Dental care
[ ] Preschool

REFERRALS

[ ] Dental
[ ] Behavioral Health _____
[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
5 YEARS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age (Years)

Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	B.P.	Health Plan Name

TO BE FILLED IN BY PROVIDER

HISTORY INITIAL/INTERVAL
Comments

T _____
P _____
R _____

NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] Referred

SENSORY SCREEN
Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer
Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
Dresses without help, knows own address, can count on fingers, recognizes most letters of alphabet, prints some letters.
(If suspicious, do specific objective testing) Assessment Tool (name) _____

BEHAVIORAL HEALTH ASSESSMENT Referral indicated? [ ] Yes [ ] No
Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

Tuberculin Test		
Urinalysis (Required)		
	High	Low
Lead Screen: Verbal Risk		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Injury prevention
[ ] Good parenting practices
[ ] Nutrition
[ ] Street safety
[ ] Should know full name, address, and phone number
[ ] Dental care
[ ] School readiness
[ ] Discipline
[ ] Household chores

REFERRALS

[ ] Dental
[ ] Behavioral Health _____
[ ] CRS
[ ] WIC
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
6 YEARS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age (Years)

Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	B.P.	Health Plan Name

TO BE FILLED IN BY PROVIDER

T _____
P _____
R _____

HISTORY INITIAL/INTERVAL
Comments

NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] Referred

SENSORY SCREEN
Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer
Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
(If suspicious, do specific objective testing) Assessment Tool (name) _____

BEHAVIORAL HEALTH ASSESSMENT Referral indicated? [ ] Yes [ ] No
Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

Tuberculin Test		
	High	Low
Lead Screen: Verbal Risk		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Good health habits
[ ] Social interactions
[ ] Good parenting practices
[ ] Bicycle helmet
[ ] Safety
[ ] Dental Care
[ ] Nutrition

REFERRALS

[ ] Dental
[ ] Behavioral Health _____
[ ] CRS
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
8 YEARS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age (Years)

Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	B.P.	Health Plan Name

TO BE FILLED IN BY PROVIDER

HISTORY INITIAL/INTERVAL
Comments

T _____
P _____
R _____

NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] Referred

SENSORY SCREEN
Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer
Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
(If suspicious, do specific objective testing) Assessment Tool (name) _____

BEHAVIORAL HEALTH ASSESSMENT Referral indicated? [ ] Yes [ ] No
Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

Tuberculin Test		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Good health habits and self-care
[ ] Family and social interactions
[ ] Good parenting practices
[ ] Regular physical activity
[ ] Dental care
[ ] Communication
[ ] Peer relations
[ ] Nutrition

REFERRALS

[ ] Dental
[ ] Behavioral Health _____
[ ] CRS
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
10 YEARS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age (Years)

Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	B.P.	Health Plan Name

TO BE FILLED IN BY PROVIDER

HISTORY INITIAL/INTERVAL
Comments

T _____
P _____
R _____

NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] Referred
SENSORY SCREEN Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer
Speech: Within normal limits? [ ] Yes [ ] No, Refer
DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
(If suspicious, do specific objective testing) Assessment Tool (name) _____
BEHAVIORAL HEALTH ASSESSMENT Referral indicated? [ ] Yes [ ] No
Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine/Neuro		

LAB/SCREENING

Tuberculin Test		
Urinalysis		
Hct./Hgb		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this child receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Good health habits and self-care
[ ] Social interactions
[ ] Good parenting practices
[ ] Educational activities
[ ] Sexuality education

REFERRALS

[ ] Dental
[ ] Behavioral Health _____
[ ] CRS
[ ] Specialty _____
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
12 YEARS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age (Years)

Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	B.P.	Health Plan Name

TO BE FILLED IN BY PROVIDER

T _____
P _____
R _____

HISTORY INITIAL/INTERVAL
Comments

NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] Referred

SENSORY SCREEN
Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer
Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
(If suspicious, do specific objective testing) Assessment Tool (name) _____

BEHAVIORAL HEALTH ASSESSMENT Referral indicated? [ ] Yes [ ] No
Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine (scoliosis)		
Neuro		
2° Sexual Dev.		
Other		

LAB/SCREENING

Tuberculin Test		
Urinalysis		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this adolescent receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Good health habits and self-care
[ ] Social interactions
[ ] Good parenting practices
[ ] Behavioral changes of early adolescence
[ ] Dental Care
[ ] Sex education
[ ] Academic activities

REFERRALS

[ ] Dental
[ ] Behavioral Health _____
[ ] CRS
[ ] Specialty _____
[ ] WIC
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
14 YEARS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age (Years)

Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	B.P.	Health Plan Name

TO BE FILLED IN BY PROVIDER

T _____
P _____
R _____

HISTORY INITIAL/INTERVAL
Comments Menarche:_____ LMP:_____ Current Meds:_____

NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] Referred

SENSORY SCREEN
Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer
Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
(If suspicious, do specific objective testing) Assessment Tool (name) _____

BEHAVIORAL HEALTH ASSESSMENT Referral indicated? [ ] Yes [ ] No
Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine (scoliosis)		
Neuro		
2° Sexual Dev.		
Other		

LAB/SCREENING

Tuberculin Test		
Hct./Hgb.		
Urinalysis (recommended)		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this adolescent receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Good health habits and self-care
[ ] Good parenting practices
[ ] Counseling about sexual activity
[ ] Social interactions
[ ] Dental Care
[ ] Nutrition
[ ] Educational activities
[ ] Pregnancy prevention

REFERRALS

[ ] Dental
[ ] Behavioral Health _____
[ ] CRS
[ ] Specialty _____
[ ] WIC
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
16 YEARS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age (Years)

Date of Examination	Ht. (in)	Percentile	Wt.(lbs)	Percentile	B.P.	Health Plan Name

TO BE FILLED IN BY PROVIDER

T _____
P _____
R _____

HISTORY INITIAL/INTERVAL
Comments Menarche:_____ LMP:_____ Current Meds:_____

NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] Referred

SENSORY SCREEN
Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer
Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
(If suspicious, do specific objective testing) Assessment Tool (name) _____

BEHAVIORAL HEALTH ASSESSMENT Referral indicated? [ ] Yes [ ] No
Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine (scoliosis)		
Neuro		
2° Sexual Dev.		
Other		

LAB/SCREENING

Tuberculin Test		
Hct./Hgb.		
Urinalysis		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Did this adolescent receive all immunizations due today? [ ] Yes [ ] No
Is there a current immunization record in the medical chart? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Good health habits and self-care
[ ] Good parenting practices
[ ] Counseling about sexual activity
[ ] Pregnancy prevention
[ ] Dental Care
[ ] Educational activities
[ ] Social interactions
[ ] Smoking, alcohol, drugs

REFERRALS

[ ] Dental
[ ] Behavioral Health _____
[ ] CRS
[ ] Specialty _____
[ ] WIC
[ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
18 YEARS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age (Years)

Date of Examination	Ht. (in)	Wt.(lbs)	B.P.	Health Plan Name

TO BE FILLED IN BY PROVIDER

HISTORY INITIAL/INTERVAL
Comments Menarche: _____ LMP: _____ Birth Control: _____

T _____
P _____
R _____

NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] Referred

SENSORY SCREEN
Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer
Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
(If suspicious, do specific objective testing) Assessment Tool (name) _____

BEHAVIORAL HEALTH ASSESSMENT Referral indicated? [ ] Yes [ ] No
Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine (scoliosis)		
Neuro		
Pelvic & Pap Smear		

LAB/SCREENING

Pregnancy Test		
Screening for Syphilis, Chlamydia, Gonorrhea		
Tuberculin Test		
Hct./Hgb.		
Urinalysis		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Immunizations current? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Dental Care
[ ] Plans for the future
[ ] Social interactions
[ ] Pregnancy prevention
[ ] Educational activities
[ ] Good health habits
[ ] Smoking, alcohol, drugs
[ ] Counseling about sexual activity

REFERRALS

[ ] Dental
[ ] Behavioral Health _____
[ ] CRS
[ ] Specialty _____
[ ] Gynecology
[ ] Prenatal Care [ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No

Early and Periodic Screening Diagnosis and Treatment
TRACKING FORM
20 + UP TO 21 YEARS

TO BE FILLED IN BY OFFICE STAFF:

Last Name	First Name	AHCCCS ID	D.O.B.	Age (Years)

Date of Examination	Ht. (in)	Wt.(lbs)	B.P.	Health Plan Name

TO BE FILLED IN BY PROVIDER

T _____
P _____
R _____

HISTORY INITIAL/INTERVAL
Comments Birth Control:_____ Menarche:_____ LMP:_____

NUTRITIONAL ASSESSMENT [ ] Adequate [ ] Inadequate [ ] Referred

SENSORY SCREEN
Vision: Within normal limits? [ ] Yes [ ] No, Refer
Hearing: Within normal limits? [ ] Yes [ ] No, Refer
Speech: Within normal limits? [ ] Yes [ ] No, Refer

DEVELOPMENTAL ASSESSMENT Age appropriate? [ ] Yes [ ] No
(If suspicious, do specific objective testing) Assessment Tool (name) _____

BEHAVIORAL HEALTH ASSESSMENT Referral indicated? [ ] Yes [ ] No
Tool used: (Pediatric Symptom Checklist, parental interview, observation, etc.) _____

PHYSICAL EXAM

Are the following normal?

	Yes	No
Skin		
HEENT		
Teeth		
Nodes		
Heart		
Lungs		
Abdomen		
Ext. Gen.		
Extremities		
Spine (scoliosis)		
Neuro		
Pelvic & Pap Smear		

LAB/SCREENING

Pregnancy Test		
Screening for Syphilis, Chlamydia, Gonorrhea		
Tuberculin Test		
Hct./Hgb.		
Urinalysis		

COMMENTS, ASSESSMENT & PLAN

Follow-up needed? [ ] Yes [ ] No

IMMUNIZATION ASSESSMENT

Immunizations current? [ ] Yes [ ] No

ANTICIPATORY GUIDANCE

[ ] Dental Care
[ ] Good health habits and self-care
[ ] Social interactions
[ ] Pregnancy prevention
[ ] Educational activities
[ ] Physical activity
[ ] Smoking, alcohol, drugs
[ ] Counseling about sexual activity

REFERRALS

[ ] Dental
[ ] Behavioral Health _____
[ ] CRS
[ ] Specialty _____
[ ] Gynecology
[ ] Prenatal Care [ ] Other

Next scheduled visit	Clinician Name	Clinician Signature

Was this claim coded as an EPSDT Visit (HCFA-1500)? [ ] Yes [ ] No